Person Centered Planning Guidelines

Revised January 2005

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Section I - Overview of Person Centered Planning

INTRODUCTION:

The Division of Mental Retardation and Developmental Disabilities requires that each person eligible for Division services have a person centered plan. These guidelines are to be used by self advocates and their families, regional centers and provider agencies, who facilitate and write plans with all persons receiving supports and services from the Division.

The Centers for Medicare and Medicaid Services (CMS previously known as HCFA), also defines and adopts the person-centered process and the values as a means of providing supports and services to individuals (CMS Home and Community Based Services Quality Framework, May, 2003). CMS provides this definition:

"Person-centered planning is a process directed by the individual, with assistance as needed from a representative. It is intended to identify strengths, capacities, preferences, needs and desired outcomes of the participant. The process may include other individuals freely chosen by the participant who are able to serve as important contributors to the process. The person-centered planning process enables and assists the individual to access a personalized mix of paid and non-paid services and supports that will assist him/her to achieve ***personally defined outcomes*** *and the training, supports, therapies, treatments and/or other services, become part of the person-centered plan".*

The CMS outcome for what they call "participant-centered service planning and delivery" states:

Desired outcome:
"Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community".

This outcome includes:

- *Assessment (Comprehensive information concerning each participant's preferences, personal needs, goals and abilities, health status and other available supports gathered and used in developing the personalized plan).*

- *Decision Making (Information and support available to help the participant to make informed selections among service options).*

- *Free Choice of Provider (to assist participant to freely choose among qualified providers).*

- *Plan is comprehensive (Addresses the participant's need for services, healthcare or other services in accordance with his/her expressed preferences and goals).*

- *Person-directed (Participant has the authority and are supported to direct and manage their own services to the extent they wish).*

CMS administered Home and Community Based Waivers, require that each person initially have a plan in place within 30 days of acceptance into the program. If the person already has a person centered plan, then the plan must be amended within 60 days to reflect what new services and supports will be provided to the person upon entrance into the waiver.

PERSON CENTERED VALUES

All plans should be in accordance with the DMRDD's Quality Outcomes. There are certain basic beliefs that form the foundation of the Outcomes and these should be considered throughout planning. These are the belief that:

- People with disabilities, their families and friends are the experts in defining what is important in their lives. It is important that we listen to and respect their expertise.
- People can express what is important to them if you pay attention and listen. It is important to provide a variety of ways for people to express their needs and wants.
- Things that are important to most community members (e.g., relationships, a sense of security, belonging, etc.) are also the things that are important to people with disabilities. This "typical community life" should be the yardstick that is used to guide us in developing supports for people with disabilities.
- Partnership and communication between the person supported, regional center and provider staff, family, friends and community members is important.
- Both the person supported and those providing support can grow through continuous learning. Continuous learning and growth should always be supported and encouraged.
- When learning or doing something new, there is usually risk involved. Growth does not occur without risk and continuous learning and growth should always be supported.
- Certain aspects of life (health, safety and legal rights) are essential to all people.
- Person centered plans should create change for and with the person being supported.
- Plans should always show the desired future of the individual and should result in real action taking place.
- When the individual desires or is experiencing a significant life change, such as obtaining employment, retirement, transitioning from school to adulthood, transitioning out of an institution to the community, transitioning from a hospital back home and planning for end of life, the planning process should be used to determine what needs to occur to safely make the change happen.
- Privacy needs must be respected.

PLANNING FOR TRANSITION

Plans focusing on life transitions should include information about:

- The person's desired or needed outcomes based upon information found in the profile.
- What steps or supports the person will need to achieve the outcomes.
- How the person's gifts, interests and talents will continue to be recognized and supported during the transition/life change;

- What works/doesn't work for the person to help develop strategies for support in the new situation;
- How the person's needs will be met, including medication, behavioral, safety and health care needs.
- Relationships that need to be maintained.
- History that should not be lost, especially related to family, behavioral supports, health and safety.
- How personal connections of those present at the planning meeting might be accessed to help the person succeed.

For example, for persons seeking employment, the plan should be used as a tool to:

- Provide a description of the person's gifts, interests and talents which can be used when developing a resume, employment portfolio or career plan;
- Provide a description of what needs to happen for the person to successfully attain employment;
- Use What Works/Doesn't Work to describe how to best support the person on the job; and
- Describe how persons present at the planning meeting will continue to support the person, i.e., developing a list of potential employers, transporting to job interviews, teaching interviewing skills, using personal connections to get interviews etc.

PLANNING FOR RISK

When the person will be learning or doing something that involves increased risk, the plan or action plan should describe:

- Efforts that have been made to assure the person is making an informed choice. What has been done to assure that the person clearly understands what risks are involved and possible consequences of their actions?
- What the person needs to know and the skills and supports that are necessary for the person to achieve their goal;
- How supports will be provided, skills that will be taught and by whom;
- What others in the community need to know and do to provide support to the individual;
- What follow-up and monitoring will occur.

INITIAL PLANS

Initial plans must contain at least an accurate beginning profile of the person. The profile needs to reflect what the person sees as important in:

- Relationships,
- Things to do,
- Places to be, and
- Rituals and routines. Rituals and routines are especially important when the person needs a high level of support in getting things done and cannot tell people how s/he wants them done.
- The plan must also contain a description of immediate needs, especially those that relate to things that are important to the person's quality of life including health and safety.

- Information about what supports and/or services are required to meet the person's needs.

The plan facilitator must make sure that each item in the action plan has enough detail and/or examples so that someone new in the person's life understands what is meant and how to support the person.

The initial plan can cover no more than 60 days, during which time a more comprehensive plan must be finalized. This more comprehensive plan will need to meet the criteria set forth in the remainder of this document.

PLAN COMPONENTS

Plans should have three main components:

- The Personal Profile describes how the person wants to live, his/her routines, what s/he wants to learn and how s/he learns best. There will be multiple sections in the profile. For example: What and who are important to the person must be included. It should describe what interferes with what the person wants as well as the ways wants and needs may be met. The profile should also describe the person's preferences regarding how supports are delivered and who will provide them (what works or does not work in supporting the person). The profile will include a demographics section and a list of contributors. Contributors are those who have provided information in the development of the plan. It includes, at a minimum, the individual, his guardian, and the service coordinator. It may also include anyone the person supported wants involved: family, friends, co-workers, direct support staff, etc. **The plan facilitator should make sure that the person supported understands that s/he may invite anyone s/he wants to contribute to the plan.**

- The Action Plan describes what the person would like to accomplish, learn or change and specifically how these outcomes will be achieved. It is crucial that the action plan reflects what priorities the person has identified as important. There should be a direct link between the information gathered in the profile and the action plan.

  Before actual outcomes and action steps are written, the planner should complete a section called: **What needs to be Maintained/Enhanced? What needs to be Changed/Different?** This is an analysis that sets the agenda for what needs to be preserved and what needs to be changed. This part of the action plan connects what is important to the person to the outcomes and action steps being developed.

  The descriptions of what needs to be maintained are things that make sense in the person's life that are currently happening and need to continue to happen, with the assistance of members of the person's circle of support. This information might include relationships that need to continue, the person being able to work at a job he enjoys and rituals that are being respected.

  What needs to be changed should focus on: a) things that are important to the person but are not present; and b) things that are present, but that make the person unhappy. This might include the person not liking a job, not getting to spend time with family or having to live with someone he does not get along with.

The plan facilitator should present the information so that it is clear whose perspective is being represented, the person, family member, friend, direct support staff, guardian etc. There are times, for instance, that a guardian may feel something needs to occur that is not a priority for the person.

If the person expresses a need, the action plan should address this need. If there is a barrier to meeting the need, then the plan should describe the barriers and offer possible solutions and timetables for overcoming them.

The action plan must include specific steps for each outcome as well as persons responsible for providing support and timelines for accomplishment. Those providing support should have access to the plan and use it as a guide for what activities need to be done with and/or on behalf of the person. Therefore, information regarding what is expected of staff should be very clear.

- Legal Issues include information about legal status; restrictions placed by the court system and dated signatures of the person, his legal guardian (if appropriate) and the service coordinator.

UPDATING PLANS

In the past, plans were developed at an annual meeting and rarely changed from year to year to reflect how the person, their goals and desires have changed. Person centered plans are expected to change and develop over time as service coordinators and others get to know the person well, spending time with him in a variety of situations and environments. We need well written plans, but the process of planning with the person is even more important than the document it produces because the process empowers the individual. Reviews/updates need to occur through discussion/dialogue with the person and their circle of support, not just a review of the person centered plan. Plans must be reviewed (and updated if necessary) on at least a quarterly basis. However, review and update of the plan must also occur when:

- The person or the person's guardian requests that information be changed or added;
- Others invited by the person to participate in his plan provide additional information; or
- The need for supports and services change. For instance, the person's level of functioning may change requiring either a reduction or increase in services. A new assessment revels additional support or service needs. The person's natural support system may expand, reducing the need for a paid service, or staff discovers another agency that will provide additional resources to the person.

When you update or otherwise change a plan, it is important that the person or his/her guardian is aware of and approves any changes made. Documenting this approval generally requires the signature of the person or guardian, but for certain types of changes and within a specific framework, there is an alternative. There are two ways to make changes to a plan. You may a) write an addendum to the plan (which requires a dated signature of the person and their guardian) or b) you may state within the plan circumstances under which information may be added without obtaining another signature.

Occasionally, a guardian may indicate that no changes may be made to a plan without prior approval. In this case, changes will need to be described in an addendum. The addendum will need to be signed and dated by the guardian prior to implementation.

Significant changes always require dated signatures. The way to include significant changes to a plan is by writing an addendum to the plan. The following types of changes are considered significant and require an addendum that includes a rationale for changes made:

- Adding or Changing an Outcome
- Adding or changing a service. (e.g. Someone begins receiving respite, someone moves from a group home or ISL);
- Proposing to restrict someone's rights; or
- Taking any other type of adverse action (e.g. canceling a service, termination from the waiver).

Informational changes do not require signatures. Changes that are primarily informational may be documented on a "working plan", in reviews or through other tools rather than through an addendum. The plan may describe circumstances under which such information may be added without obtaining new signatures. Types of changes, which may be made in this way, are:

- The additional information provides clarity to a section on the plan. (e.g. the plan states the person does not like sports, but it is discovered that he likes swimming);
- More detail is added to a plan that does not require a change in the outcome (e.g. The outcome states the person enjoys and wants to go to movies but later it is discovered that he does not like romantic comedies); or-
- The action step or strategy is not working for the person, but the outcome remains the same. Action steps and strategies for obtaining the outcome may change without an addendum being completed as long as it does not result in a change in services and supports.

<u>In these situations, the outcome must have an action step that describes how staff would document and share what they have learned with the rest of the support team</u>.

For example:

Outcome: John will become more familiar with recreational activities in his community.

Rationale: John just moved to this area. He enjoys swimming, walking and reading. He wants to learn what is available and decide which activities to pursue.

Action Step:
Staff from the ABC Center will assist John in accessing community resources for swimming, reading and walking three times a week.
Monthly notes will document John's reaction to the activity and whether:

- John wishes to attend similar events in the future,
- John wishes to join a class, club or organization
- John wishes to pursue other interests.

Direct support staff may share information about the person in a variety of ways such as sharing progress notes, at monthly meetings, providing a "working plan" to support staff on which to write insights, etc. The person, his/her service coordinator or plan facilitator

must decide how to incorporate the information into the plan and make sure it is done. The plan facilitator must ensure the accuracy of information provided, which may be done by asking the person, observing behavior, or checking with those who know and care about the person.

PLANS AND OTHER WAIVER DOCUMENTATION

Section 13.9 A of the waiver manual contains information regarding documentation requirements for persons receiving waiver services. It states that

> "**Implementation of services *must* be documented by the provider and is monitored by the service coordinator at least monthly for individuals who receive residential habilitation or individualized supported living and at least quarterly for individuals who live in their natural home. The provider is required to document the provision of MRDD Waiver services by maintaining:**
>
> - attendance or census records documenting days of service signed by the provider or designated staff;
> - daily activity records that describe various covered activities (services) in which each person participated;
> - records of which staff provided each unit of service;
> - documentation that each such staff is qualified to provide the service;
> - progress notes by direct care staff regarding situations or incidents (good or bad) that arise affecting the individual, and;
> - monthly summaries that describe progress on the individual's person centered plan goals and objectives and overall status of the individual.

All providers must follow the above documentation requirements unless otherwise noted under specific MRDD Waiver services in Sections 13.16 through 13.33 of the waiver manual. Non-waiver service providers are expected to have similar documentation. The service coordinator is responsible for ensuring that waiver documentation requirements are met.

Information in the plan, reviews, monthly reports etc. also needs to be consistent with and not contradict information in other waiver documentation. Before entering the waiver, a service coordinator determines eligibility for the waiver by completing the Evaluation of Need for an ICF/MR Level of Care Form (ICF/MR or LOC form). (See Appendix A, pg 22) This form documents the person's eligible diagnoses and that without the waiver; the person would require active treatment in an ICF/MR. When developing the plan, service coordinators must consider the seven (7) functional areas identified on the form where the individual requires supports and document in the plan how these supports will be provided.

For individuals who are residing in an ICF/MR and who are transitioning to the community, plans will need to reflect that habilitation professionals are working to transition the individual to community services; however an ICF/MR level of care continues to be needed. The plan must describe how these needs will continue to be met in the ICF/MR until the person actually moves to the community. The plan must

also describe how the needs will be met in the community after the person moves from the institution.

The ICF/MR form takes its cue from the MOCABI and other functional assessments. Presumably, any "significant functional limitation" on these assessments would represent an issue for the person. A limitation would be considered an issue if supports or services are needed for it or if staff need to know or do something to ensure something happens (or continues to happen) for a person.

The seven (7) functional areas from the ICF/MR Level of Care form are listed below.

- Medical
- Behavioral
- Communication
- Cognitive Abilities
- Daily Living Skills
- Motor Development
- Socialization

The person-centered plan needs to contain clear information reflecting each functional limitation noted on the LOC form, with the exception that cognitive abilities will not always have a specific action or support associated with it. Limitations in cognitive abilities tend to cause or compound limitations in other areas and the plan overall should identify what is being done to meet the person's needs in those areas.

How the limitations in the level of care form are reflected in the person centered plan will vary significantly. Goals or objectives are NOT necessary for each indicated limitation; however, if the limitation presents an issue for the person, the plan must communicate what is to be done about it i.e. what services and supports will be provided.

SERVICE COORDINATOR RESPONSIBILITIES

There will be times when the person, family member, guardian, the provider or someone else of the person's choosing, will want to direct the person centered plan. This is perfectly acceptable. When this occurs, the service coordinator is still responsible for the following:

- Ensuring eligibility for the waiver through the use of appropriate assessment tools (MOCABI, Level of Care Determination form, Vineland, etc).
- Ensuring that waiver documentation requirements are met.
- Reviewing other assessments that have been conducted (health, behavioral, risk etc) prior to developing or updating a plan and ensuring that recommendations regarding additional support or service needs are addressed in the plan.
- Knowing when plans are due and assuring that planning meetings are conducted in a timely fashion.
- Making sure plans are dated and signed at least annually by the person, his guardian and the service coordinator.
- Making sure addendums are dated and signed by the person, their guardian and service coordinator.
- Reviewing the plan to make sure the guidelines described in the remainder of this document are met.

- Supporting the person and whoever is writing the plan in understanding the guidelines described in the remainder of this document.
- Ensuring that the guardian, support staff and the person have copies of the plan.

The material that follows was created to assist service coordinators in developing plans that meet both person centered planning and waiver criteria. In instances where someone else writes the plan, the service coordinator continues to be responsible for ensuring these criteria are met. Service coordinators should use the material under the Person Centered Planning Guidelines for reviewing plans written by others.

PROVIDER RESPONSIBILITIES

When the provider facilitates the development of the person centered plan, the service coordinator will work with the agency to ensure that the plan meets guideline criteria. Providers working with an individual are also responsible for:

- Informing the service coordinator / guardian of any issues that arise while implementing the plan, including the inability of the provider to provide supports or services prescribed in the plan;
- Informing the service coordinator / guardian of any need for changes to the plan; and
- Documenting the provision of supports and services according to Sections 13.9 a / b and 13.16 – 13.33 of the Medicaid Waiver Manual.

When a provider facilitates the development of the person centered plan, **the service coordinator responsibilities listed in the previous section, do not change.**

PROVIDER QMRP RESPONSIBILITIES:

Whether the provider facilitates the plan or participates in its development as a member of the interdisciplinary team, the provider Qualified Mental Retardation Professional (QMRP) has the following responsibilities:

- Actively participate in the person centered planning process.
- Provide supervision and training to direct support staff regarding implementation of person centered plan.
- Design support and teaching strategies (i.e. training plans, teaching methods) for implementation. Ensure support and teaching strategies are referenced in the person centered plan.
- Make changes to support / teaching strategies to ensure progress toward achievement of outcomes and action steps.
- Regularly monitor the implementation of the person centered plan.
- Make necessary changes to the person centered plan outcomes based on collection of data, direct support staff feedback and observations of the consumer working toward plan outcomes. Outcomes may only be changed with the approval of the person, their guardian and other members of the interdisciplinary team.
- Ensure that services and supports are provided as specified in the person centered plan.
- Provide service coordinator with monthly reports on progress.
- Facilitate opportunities for natural supports.
- Document specific QMRP activities provided to the individual.

Section II - Developing the Plan

PERSONAL PROFILE

This information is not a mandated form or format for planning. The headings listed do not have to be used in a plan. Information may be in a narrative format or any other form that makes sense to the person as long as the required information is included.

The term mandatory means that the topic is required. Optional means that addressing the topic is left to the choice of the person and/or their guardian. Contingent means that if appropriate to the person and situation, the topic is required.

Special Note: See Introduction of planning guidelines page 3 for initial plan requirements. Examples for each section of the guidelines are located in the Appendix B of this document.

1. Demographics:

• Full Legal Name	Mandatory
• Nicknames	Optional
• Age and/or Birth Date	Mandatory
• Primary Language Used	Contingent (Required if the primary language is other than spoken English. If sign language is used, state what type of sign.)
• Method of Communication	Contingent (Required if the primary mode of communication is other than speaking: communication boards, etc.)
• Diagnoses*	Contingent
• Personal Plan Meeting Date	Mandatory
• Personal Plan Implementation Date	Mandatory

*If a diagnosis is listed, the plan should also indicate if there are related supports that need to be in place. Example: If a person has a diagnosis of Diabetes, supports should be listed under "What supports are needed for health."

See Appendix, Example 1.

2. Contributors (Information about this topic is mandatory.)

People we support sometimes do not understand that they may choose who contributes to their plan and attends their planning sessions. They may need to be taught that their friend from work or the person they are dating may be asked to come to the meeting or contribute in other ways. Having a variety of individuals who know and care about the person assists in developing a clear picture of the whole person. These individuals can provide access to information or viewpoints we may not otherwise have.

- Who contributed to the plan through interviews, reports, letters, questionnaires, etc.?
- Who was present at the plan meeting?

See Appendix, Example 2

3. **Who is important to the person:** It is important to know about the person's social support network. This includes who is important to the person, what the person likes to do with them and about how often. Information about this general topic (important relationships) is mandatory; however, the detailed information is expected to vary significantly.

• Statements from people who know and care about the person	Contingent
• Information about family including names, ages (if children), relationship to the person, the person's level of interest in maintaining or building a relationship with the family member	Contingent
• Information about friends & neighbors	Contingent
• Information about community members and how the person knows them	Contingent
• Paid staff who are important to the person	Contingent

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 3 – 6.

Information discovered under the following topics must be synthesized in a way that will guide planners, the person and their support staff in developing outcomes that will have a real impact on the person's life. Uncovering a person's gifts and abilities, looking at potential contributions the person can make and knowing how they are best supported will lead us to places in the larger community where the person's identity can truly emerge through the development of valued roles, relationships, meaningful activities etc:

- What is important to the person?
- What do we need to know to support the person?
- What supports are needed for health?
- What supports are needed for safety?

4. What is important to the person: Information about this topic is **mandatory**. However, the specific kinds of things covered are expected to vary significantly.

This topic should include a description of what the person thinks is important to have a reasonable quality of life. **What is important to others should be kept separate. When reading the plan, it should be easy to distinguish what is important to the person from what is important to others.**
Information may be prioritized to reflect what is critical, very important and/or enjoyable to the individual.

You should state information very clearly in order to avoid misinterpretation by support staff. You can avoid misinterpretation by including more than just a list under the topics below. For instance, the plan should not simply state that a person likes movies; it

should also explain what type of movies the person enjoys, and when, where and with whom he enjoys watching them.

Hopes, Dreams & Wants	Mandatory
Needs	Mandatory
Likes & Dislikes	Mandatory
What the Person Would Like to Try	Mandatory
Places That Are Important to the Person	Contingent
Special Interests	Mandatory
Traditions	Contingent
Ethnic Heritage	Contingent
Cultural Events	Contingent
Support Preferences (e.g., Does the person prefer a woman or man for specific tasks like bathing?)	Mandatory

When discussing and documenting 'What is Important to the Person?" consideration must be given to not only what is important now, but also what will be important to the person in the future. Having a vision for the future may guide us in understanding what the person needs to learn now or what we need to do now to make future goals possible. "Certain hopes may not always be possible. However, there may be obtainable items or re-occurring themes that can be achieved in that person's life." (Beth Mount)

Knowing how the person's support needs are likely to change in the future may help us prepare for meeting those needs in a timely and effective manner. For example, if we know that a person will need an increased level of nursing care within the next several years we can begin to plan for finding resources to meet those needs, make sure we document relevant information to assist future care givers, make sure supports are in place to help the person cope with the change in their medical status etc. If there are transition issues, such as graduating from school and going to work or moving from a institution to community living , obtaining a vision of what the person would like their future living arrangement or job to be will help us to plan and provide supports that will lead to a future that is desirable to the person.

There is an expectation that information here will be acted upon, if not now, then by a specified time period. You should revisit future needs, dreams and goals as part of the monthly review.

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 7 A – B.

5. What do we need to know in order to support the person? This information describes what "OUR" behavior needs to be to support the person and is **mandatory**. Information should be based on what the person has told us is important. Staff roles and responsibilities when providing supports could be explained here. It may be helpful to develop a list of all of the items in the support section that need monthly follow-up to assist staff in

providing support and to ensure that supports are being addressed and maintained. This information must include:

- A description of how supports should be delivered.
- How a person learns best.
- If the person has behavioral concerns, they may be described along with what we think the person is trying to communicate through this behavior.
- A description of what alternative skills need to be taught to replace the undesirable behavior should also be included.
- It describes what is already happening and needs to continue to ensure consistency in the way supports are delivered.

Information about things to do, try, and learn or to be enhanced should be addressed in the action plan.

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8A

6. What supports are needed for health, if any? The plan **MUST** address the person's health whenever there are important issues in this area. This information is contingent in that it is only required if the person has needs in this area. One way to address health issues is to add a heading to the plan called, "What we need to know for (the person) to remain healthy or meet his/her health care needs." Information should be stated very clearly so that support staff know exactly what must be done to address each health concern. Additionally, information may be included about maintaining good health and might include things such as exercise programs.

A person may choose not to have intimate health or personal care issues detailed in their plan. However, support information must be available elsewhere and the plan must specify: 1) where the information is located and 2) that staff must use this information to guide what supports they provide. For example, a person may need very specific supports surrounding bathing. He may not want his plan to contain a description of how he is to be bathed. In this case the plan must indicate that: 1) he needs assistance with bathing and 2) staff that are responsible for providing support with bathing must be trained to follow and use the bathing checklist located in the medical record.

Keep in mind that the person may not perceive vital issues of health as important. The plan should still describe the issues of concern while making it clear that the person does not agree. One way to address this situation is to add a heading to the plan called, "Things we think are important and need to know and/or do even if the person does not agree." The following areas of health should be considered:

- Medical or dental conditions — Contingent
- Needed follow-up — Contingent
- Medications, treatments, or procedures (Information should include reason for — Contingent

taking medication, possible side effects, etc.) *

- Infection control issues — Contingent
- Immunization needs — Contingent
- Dietary needs — Contingent
- Allergies — Contingent
- Issues around how medical/dental supports are to be provided. — Contingent
- Issues around Mental Health — Contingent

There are a variety of ways that the usage of medication may be addressed in the plan. A list of routine medications and the reason for taking them may be contained in the plan or you may reference that the individual is taking medications for a particular reason and indicate where a list of current medications may be found. Monthly reviews should reference concerns with or changes in medications,

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) if there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8B

7. What supports are needed for safety, if any? This information **MUST** be included when there is a need to highlight important or extensive safety issues. This information is contingent in that it is only required if the person has needs in this area.
Information should be stated very clearly so that support staff know exactly what must be done to assist the person in staying safe. Keep in mind that the person may not perceive vital issues of safety as important. The plan should still describe the issues of concern while making it clear that the person does not agree. One way to address this situation is to add a heading to the plan called, "Things we think are important or know and/or do to keep the person safe even if he does not agree."

Behavior that puts the individual or others at risk may be described here. The behavior should be described in terms of what the person is trying to communicate through his behavior and alternative skills the person needs to learn to replace the undesirable behavior.

Some examples of safety concerns may be:

- Emergency Safety — Contingent
- Support needed while cooking — Contingent
- Support needed when away from home — Contingent
- Other supports needed in the home (answering the door, etc.) — Contingent
- Behaviors that put the person or others at risk — Contingent

There may be safety issues that are not extensive, but still need to be pointed out. One way to describe these issues would be under the section called, "What we need to know in order to support the person."

Example: John does not pay attention to weather conditions. This may be documented under "What we need to know in order to support John" by stating "Staff always need to remind John to wear a coat outside when it is cold."

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 8C.

8. Requirements of family of minor child or guardian? If the person is a minor child, information from the parent(s) or guardian **MUST** be included in the plan. If the person is an adult with a guardian, information must be included if the guardian requests that it be included. The action plan should then describe how the guardian's concerns are being addressed.

There may be situations where it is necessary to include information regarding what people need to know or do that the person disagrees with. Information such as this should be included in the plan but it needs to be made clear that the person does not agree with what is written. One way to provide clarity would be to include a section titled "Things the guardian thinks are important and that staff need to know or do, even if the person does not agree." Health or Safety issues that must be addressed to support the person in staying safe, but that the person does not consider important may be included here.

- Parents of Minor Child — Mandatory
- Guardian — Mandatory

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 9A

9. How the Person Communicates

This section is contingent, based on the needs of the individual. A communication section is recommended for those people who have their own unique way of communicating. It is very useful when people do not use words to talk or who have difficulty in using words. One way people communicate is through behavior. It may be important to chart certain behaviors and what the person is trying to communicate in order to reduce incidences of unacceptable behaviors. The chart may help us to understand the communicative intent of the behavior and actually gives us cues when some type of redirection, other non-intrusive form of behavioral supports, and/or teaching new skills could be used successfully. Many of the individuals with whom we work are very articulate; however have difficulty expressing their emotions or

feelings with words. Often it is their body language that communicates that clearly something is troubling them. If these types of behaviors are clearly outlined in this section, it may prevent an escalation of behaviors.

In these cases it may also be necessary to teach alternative methods of communication. If this is the case, the desired outcome and teaching method should be described in the action plan.

There are many people who communicate very well using sign language or augmentative devices. This section is not needed for these individuals, but rather only for those people who have significant communication difficulties. Document situations where the person successfully uses alternative ways to communicate under Section 1, "Demographics, Method of Communication." (See page 10 of this document.)

An example of a communication section follows:

When this is Happening	And Sue Does this	We think it Means	And We Should
Sue comes home from visiting mom	Slams the door and goes to her room	She is upset about having to leave her mom. She misses her.	Make sure she has space until she approaches you. Give her a hug. Spend time with her doing something she enjoys (puzzles, having an ice cream, sitting on the porch).
Sue is eating	She turns her head	She is finished	Remove my food now. (If you do not remove the food, Sue will throw her plate on the floor.)
Sue goes into the community	She points to her communication board	Sue needs to communicate with someone	Explain to the listener that Sue communicates with her communication board. Make sure Sue has her communication device at all times in the community.
Sue's communication device does not meet her need for a particular conversion / event	Sue shoves the board away	This device is not able to convey my thoughts!	Help her program her communication device or assist her in being able to communicate in a different way.

You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) if there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Examples 10 A – C.

10. Issues to be resolved/concerns

This section is optional. This topic provides a vehicle for documenting differences of opinion among members of the team or circle of support. For example:

- The person wants one thing and the guardian wants another. (E.g., the person may wish to move back home, but the family does not want this to happen.)
- There may be a lack of information about a particular situation, (e.g., a guardian has requested that the person not have contact with a particular person, but no one knows why.) or
- There is a limited availability of options that may hinder immediately working towards an outcome. (E.g., the person wants to live in his own apartment, but needs to find a roommate to share expenses and defray staff costs.)

If there is a disagreement about if or how something should be done or if more information is needed, the plan should describe a strategy for resolving the conflict or obtaining additional information. The plan should include time lines for resolving the issue.

> You may need information from this part of the profile to develop the action plan. Ask yourself two questions and note your answers: a) If there are things of importance that need to continue, does any member of the support team need to do anything to ensure those things happen? b) Do some things need to change?

See Appendix, Example 11

ACTION PLAN

Action Plans are mandatory. The action plan describes what the person wants to learn, do, change or maintain with the assistance of his support team. It must list what staff will do to support the person, who will do it and a target date for accomplishing each support step. The action plan should be clear so that those providing support will know exactly what needs to happen for the person. A few words to describe an outcome include: the result, the "big picture," the ultimate place to be. **Action plans that contain only a list of services to be purchased DO NOT meet HCB Waiver or Person Centered Planning criteria.** Services are a way of impacting people's live. The impact that the service has should be your outcome, not the service itself. Points to remember about outcomes:

- An outcome IS NOT a service or service definition such as "will receive residential habilitation". Hopefully, the result is not the residential habilitation but **how** this service impacts the person's quality of life.
- An outcome IS NOT a support statement such as "will continue to received 24 hours support from staff"
- An outcome IS NOT the action, but represents the result or "big picture". Services are not outcomes.
- The action plan contains: action steps and support strategies. This is the action it will take to make the outcome a reality.

Each action plan must contain the following information:

1. **What Needs to be Maintained/Enhanced or Changed/Different:** Begin action planning by reviewing what you have learned from the information gathered in the profile. In this part of the action plan, you compare the present (what is happening) with what should be happening. Determine what needs to be maintained/enhanced and what needs to be changed/different. You should already have this information if you have completed the assessment questions at the end of each profile topic (Above). If you have not already conducted this assessment, do so before writing outcomes and action steps.

   There may be times when family or staff feel something needs to continue (such as the person receiving psychotropic medication) that is not important to the person. It should be clear whose perspective is being represented in the plan. The chart that follows is an example of one way to organize this information:

	What Needs to be Enhanced/Maintained? (What makes sense)	What needs to be Changed/Different? (What doesn't make sense)
From the Person's Perspective?	• Continue to go to his brothers each Sunday to watch football. • Staff needs to remember that John showers right when he comes home from work. • Continue to live in the Independence area by his brother.	• Would like to see his mom more, but she lives an hour away and does not have transportation. • Would like to look for another job, as he does not like the workshop. • Staff need to understand how he communicates.

The information in this chart should then be used to develop the outcomes and action steps.

2. **Your next step is to use the information gathered above to develop outcomes. The outcomes should reflect the personal profile and what needs to be maintained or changed/different. You need to include rationales stating why the outcome is important to the person. These rationales may be stated as part of the outcome or included in the profile of the plan.**

   Having a direct link from the action plan back to the plan's profile and to what needs to be maintained or changed/different helps to ensure that we are supporting the person in learning and doing the things that he feels is important. The action plan may describe what the current situation is and list ideas to change the situation. This list of ideas should be part of the action steps. Staff should have a way of determining if there is movement towards accomplishing the outcome. If staff cannot measure whether something is happening for a person, it could be because the outcome is not written clearly enough.

3. **The action plan must describe strategies for providing the supports a person needs to work towards outcomes and to assure health, safety, and welfare.**

The action plan needs to state what issues the person has in these areas. It also needs to state specifically what will be done to support the person to stay safe or to maintain health. These action steps should tell us how and what a person or their support staff will do to achieve the outcome related to health or safety. The strategies described should be specific enough that those unfamiliar with the individual can read it and determine exactly what must be done to provide support.

Sometimes a person may choose to keep very private information separate from the rest of the plan (e.g., a description of how he wants to be bathed). This is acceptable; however, the plan must make it clear that this information exists and state where it may be found.

4. **An action plan must include the names of persons responsible for implementation of each action step and time lines.**

   The person supported and/or a guardian needs to know who is supposed to be held accountable for ensuring each specific support is provided, who he may go to for assistance, etc. This may be the direct support person in the home or someone else designated by the agency who is responsible for making sure action steps occur. Staff needs to know what specific tasks they are responsible for.

   Timelines should be specific and should vary according to how complicated the tasks are. For instance, if a person has a goal to learn to drive, it may take only a day to go to the license bureau to pick up a book for the person to study, but it might take several months for the person to actually prepare for the test. Service coordinators can then use this information to check on the progress of each action step during the review process.

5. **Each outcome should include a statement describing what achievement of the outcome will look like. How would an outside observer know it had been achieved?**

   For instance, if a person expresses a desire to improve their relationship with a family member we might know this has been achieved through a variety of ways. The family member may initiate visits more often, send birthday gifts and/or appear more comfortable with the person as evidenced by sharing memories and laughter. It is important to understand exactly what we want to achieve and when it is achieved so that successes may be celebrated.

See Appendix, Example 12 A - D

LEGAL ISSUES

This section is mandatory.

1. Legal status

2. Guardianship: Name, address, phone number and relationship to the person of the person's legal guardian, if applicable

3. Specific restriction(s) placed by the court such as whether a parent is able to visit a child who has been removed from their custody.

4. Specific restriction(s) to legal rights, documentation of due process, length of time restriction(s) will be in place and, if appropriate, positive behavior support information. The plan should indicate what skills need to be learned so that rights may be restored, how these skills will be taught and what steps will be taken to restore the person's rights when the restrictions are no longer necessary,.″

5. Consent for Treatment: Signature of the person and, if appropriate, their parent or legal guardian signifying their consent for the treatment prescribed in the completed plan. The plan must be signed prior to the date of implementation as consent for treatment is not in place until the plan is signed and dated. The person and their guardian must be given a copy of the plan. The regional center must be able to document that the person and guardian have been sent a copy of the plan. The following statement must be on the signature page:

"My signature below gives consent for service delivery as outlined in the personal plan dated _____, which I have reviewed and approved. (RSMO 633.110)"

6. Other Required Signatures: Signature of service coordinator and/or the regional center representative is required along with those listed under Consent for Treatment.

7. Provider Choice: If this section is included in the plan, the signatures of the person and/or their legal representative must be on the same page as the statement of provider choice. Including this information in the plan does not eliminate the need for the regional center to document choice through the Client Choice of Provider Statement (Form Number 650-7642).

Recommended Readings on Person Centered Planning:

- **Smull, Michael, Sanderson, Helen, & Harrison, Susan** 1996 Reviewing Essential Lifestyle Plans: Criteria For Best Plans. Michael Smull, 3245 Harness Creek Road, Annapolis, MD 21403
- **Mount, Beth and Zwerk, Kay** 1989 It's Never Too Early, Its Never Too Late A Booklet About Person Futures Planning. Metropolitan Council Moers Park Centre, 230 E 5th Street, St. Paul, Minnesota 55101
- **DiLeo, Dale** 1994 Reach For the Dream! Developing Individual Service Plans for Persons with Disabilities, Second Edition. Training Resource Network, PO Box 439, St Augustine, Fl 32085-0439
- **Mount, Beth 1995** Capacity Works: Finding Windows for Change Using Person Futures Planning. Graphic Futures, 25 West 81st St, 16-B New York, NY 10024

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX A

_____ Initial Determination _____ Annual Re-determination

Evaluation of Need for an ICF-MR Level of Care and Eligibility for the MRDD Waiver

Person_____ DMH#_____

New Date of Eligibility for Waiver_____ Regional Center_____

The purpose of this form is to determine and document whether or not the above named person has a need for the level of care provided in an ICF-MR and if so, would he or she require ICF-MR placement if not provided services under Missouri's Home and Community Based Waiver for persons with developmental disabilities.

I. Is the person eligible for ICF-MR?

A. Diagnostic determination of Mental Retardation or a Related Condition which would otherwise qualify him/her for placement in an ICF/MR:

1. Diagnoses: Axis I_____ Axis II_____ Axis III_____

2. If the diagnosis is of a related condition, document the person has functional limitations in THREE (3) or more of the following areas of life activity or, if a child, has or is likely to have, functional limitations in at least three equivalent, age appropriate major life activities:

Self Care ____ Learning ____ Self Direction ____
Capacity for Independent Living ____
Receptive and Expressive Language (development & use) ____ Mobility ____
See Attached (children only) ____

B. Does this person have a need for a continuous active treatment program, including aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that are directed towards the acquisition of the behaviors necessary to function with as much self determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status? YES___ NO_____.

Indicate, by checking below, the limitations this person has which require active treatment:

____ Medical: Has a medical condition that requires ongoing treatment and support.

____ Behavior: Engages in behaviors that are aggressive or self injurious and therefore requires support from staff to encourage positive social interactions and to prevent injury to self or others.

____ Communication: Due to limitations in hearing, speaking, reading and/or writing this person has difficulty expressing or understanding written and spoken communication.

____ Cognitive abilities: Difficulty in processing and understanding information. The rate at which this person learns may be considered slow and creates difficulty in acquiring complex skills.

____ Daily living skills: has difficulty carrying out age appropriate daily routines with regard to personal hygiene, financial management, household chores and/or nutritional needs.

____ Motor development: has difficulty moving about independently and safely resulting in problems accessing the community, operating household equipment and or performing activities of daily living.

_____ Socialization: does not possess adequate social skills necessary to establish and maintain Interpersonal relationships with peers, relatives, co-workers and other community members.

____ Other (specify):_____
_____

II. Is there a reasonable indication, based on your observation and assessment of this person's physical, mental and environmental condition, that he/she will need placement in an ICF/MR unless provided home and community based services under the waiver? YES____ NO____

Summarize the information that supports the above conclusion:

_____
_____
_____
_____
_____
_____
_____
_____

III. List below all assessments and evaluations on which you based the conclusions above. For each entry, document the type of evaluation/assessment and by whom and when it was completed. In addition, for evaluations/ assessments which were performed over 30 days prior to this level of care determination, also document the date you reviewed the information and on what basis you believe it is still accurate.

_____
_____
_____
_____
_____
_____
_____

ATTACH ADDITIONAL DOCUMENTATION IF NECESSARY

This information is maintained where? _____case record, ____other location (specify)

_____

IV. _____ _____ _____
Signature Title Date

PERSON-CENTERED PLANNING GUIDELINES

APPENDIX B

INTRODUCTION

INTRODUCTION

The overview section of the Guidelines Manual explains the requirements of the Department of Mental Health, Division of MR/DD regarding personal plan development. The values of the Department are in accordance with the Missouri Quality Outcomes; therefore, personal plans must also be in accordance with these values.

What are the Missouri Quality Outcomes?
The Missouri Quality Outcomes is the result of listening to people with disabilities and their families. It describes a collection of positive outcomes identified by people with disabilities. This collection is in the form of a discussion guide that is intended to serve as a tool to put into practice what individuals tell us every day:

- To have productive, meaningful lives
- To be full members of a community like any other citizen
- Typical life in the community is the benchmark for quality life

Outcome #11 of the Missouri Quality Outcome states:
"*People's plans reflect how they want to live their lives, the supports they want and how they want them provided"*.

Why guidelines?
The person-centered planning guidelines are a balance between "system requirements" (what is required for funding for developing person-centered supports and services) and "best practice" for developing person-centered plans. The goal of the appendix is to assist teams, planning facilitators or anyone in need of understanding the personal plan process with developing supports and services through the Division of MR/DD. The personal plan process is a framework for discovery, decision making, understanding and learning about a person, and a means for taking action to assist a person to build a desirable future that makes sense to him/her. The guidelines are a means of getting started with this process.

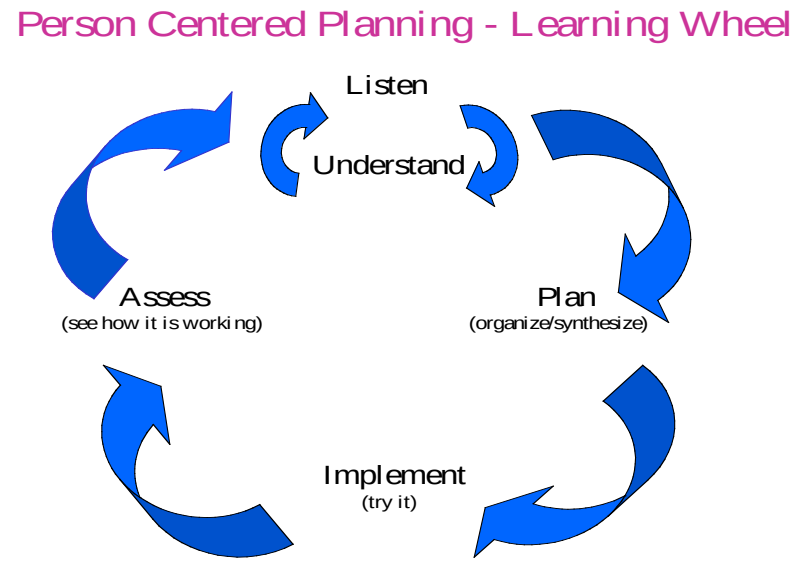
A process for person-centered planning is adopted by many states as a means of defining how supports and services are delivered and to define state values. Other states have also established *guidelines* for personal planning to ensure plans implement values of self-determination.

Principles of Self-Determination:

FREEDOM
To live a meaningful life in the community
AUTHORITY
Over dollars needed for support
SUPPORT
To organize resources in ways that are life enhancing and meaningful
RESPONSIBILITY
For the wise use of public dollars
CONFIRMATION
Of the important leadership that self advocates must hold in a newly designed system

Defining the process:

The term "person-centered planning" became common by the 1980's. It represents an approach for seeing the person first rather than relating to a diagnostic label, using ordinary language rather than professional jargon. The process actively searches for a person's needs, gifts, interests, capacities in the context of community life, and it should strengthen the voice of the person and those who know the person best. This process evaluates the person's current situation to **define what health, safety and risk means** for the person and seeks a desirable change that makes sense *to* and *for* the person.



- *Smull, Allen - The ELP Learning Community*

The Centers for Medicare and Medicaid Services (CMS previously known as HCFA), also defines and adopts the person-centered planning process / values as a means for providing supports and services to individuals. (This is described in the overview section of the guidelines).

Person-centered planning is viewed as a core component of quality service delivery. The person is the central driving force in determining the future vision, goals, supports and services. It requires the team to do the following:

- Listening to the person and understanding what a *desirable* lifestyle means *to* and *for* the person, always seeking to find the *balance between* health, safety, and risk issues

- Plan means to attend to the details (develop the document), identify the supports and services that really matters *to* and *for* the person, encourage the contribution of the person's dreams and desires, and be open and sensitive to situations that can be difficult and confusing

- Implement and assess means the outcomes are in "active" status, the team asks the following questions: what have we learned, what have we tried, what needs to be changed, enhanced or maintained? The answers to these questions are acted on to determine what's working or not in the life of the person, the plan changes as the person's life changes.

PERSON-CENTERED THINKING:

The person-centered process is a shift in the way we *think, what we do, and how we do it* ("person-centered thinking") and specifically *how we do business* in supporting people with disabilities. We are constantly challenged by the work we are required to do within "the disability system" which often makes it difficult to balance the values we must practice to truly do good person-centered work.

The following examples describe some of the differences between traditional and current practices in the way we should *think, act, and do business* in a person-centered way.

Traditional Process	Person-centered process = person-centered thinking and planning
A team of service providers meets annually with the individual and/or family members to develop a plan for services.	A support team made up of the individual, legally authorized representative, family members, service providers and other community members meet as frequently as needed to develop and implement a future vision and goals for the individual. The team will meet based upon the needs of the individual, but at least annually.
Relies only on standardized and non-standardized tests and assessments that highlight deficits. Looks at the person in need of services and who has to get "ready" for community life.	Spends time getting to know and discovering the person. The support team gathers and organizes information into a personal profile, develops the future vision and outcomes with action steps that leads to achieving the outcome.
The individual and family members participate in the development of a service plan.	The team assists the individual in a respectful and competent manner to actively lead and/or participate in the meeting.
Establishes goals that are already part of existing programs. The plan is designed to fit the person into a particular program even if that program is not exactly what the person needs or has interests.	The individual, family members, friends, and general community members define the personal profile and future vision and look to service providers for supports. Programs are developed around the needs of the individual.
Relies primarily or solely on professional judgment and decision-making.	There is shared decision making with the person, families, friends, and those who provide supports and services.
A service plan is mandated that guides the services received. The service IS the outcome.	The content of the plan provides a snapshot of the person and drives the need for outcomes and action steps. The action taken drives the supports and changes to be implemented.
Implementation of the plan is ensured through provisions of professional services.	Implementation of the plan depends upon the commitment and partnership of the team and their connections with the individual.
Goals are developed based on "programmatic" needs.	Outcomes are developed based on: • The person's current situation • What's working vs. not working in the person's life • What is important *to* and *for* the person • Things that need to be changed, maintained or enhanced in the person's life • Values of the Missouri Quality Outcomes ("typical" life in the community)

To self-advocates and families:

Signs of adequate planning and support for self determination: (adapted from "It's my meeting – a family and consumer guide to participating in person-centered planning)

- Team members are active listeners, understand who you are, what you need and want in your life.
- You are supported to express yourself.
- Decisions making is shared.
- There is shared understanding of advice given to you (and/or your representative).
- Choices are provided (to you and/or your representative).
- You (and/or your representative) are comfortable with the time and place of the planning meeting.
- You chose and are aware of all participants on your team.
- The planning document reflects your needs, desires, preferences, capacities and states your desired outcomes for reaching your goals (long and short-term).
- The planning document is changed and/or updated as often as your life changes or as often as you request.
- The planning document is not impersonal or disrespectful.

LIFE TRANSITIONS

A VISION FOR THE FUTURE

Person-centered planning and life transitions:

Person-centered planning is also a process to support an individual in transition. Transition examples include:

- Graduating from school, transition to adult life
- Finding employment or changing jobs,
- Moving to a new home (from a parent's home, institutional setting, nursing home, hospital, etc.) to life into the community,
- Living with someone new,
- Coping with the death of a loved one
- Health changes and/or aging issues
- Retirement
- Locating a provider agency,
- Meeting new people, trying new things, and going to unfamiliar places, etc.

The purpose of a person-centered transition planning process is to ensure all team members involved are on the same page, share the same vision and commitment for change. Teams also must make sure valuable and complex information is shared (such as what is important *to* and what is important *for* the person regarding supports, services, health, safety and risk) during the transition.

Transition planning should be a purposeful, organized and outcome-oriented process designed to ensure the person's quality of life. It is very important to begin early to allow time for planning the supports and services needed for the future.

Any transition process can present complex issues and anxiety for the person. It can also be a traumatic experience to the person which means it is critical that planning teams address all sensitive areas to meet the needs and preferences of the person. It is also critical that those who know the person best from all settings participate in the planning process.

The components outlined in the *person-centered guidelines* can assist with developing a good initial transition plan.

General guiding principles of transition *(Adapted from "Best Practices for Transition Services" – California Transition Coalition)*

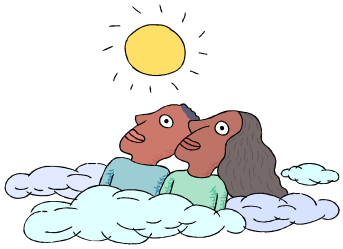
⇒ *Implement person-centered planning*
⇒ *Focus on the person / family*
⇒ *Ensure the health, safety, and well-being of the person in transition*
⇒ *ONE PLAN in transition with the person*
⇒ *Focus on outcomes*
⇒ *Improve quality of services*
⇒ *Provide user friendly and culturally sensitive services*
⇒ *Be cost effective*
⇒ *Ensure collaboration between and within agencies*

⇒ *Provide opportunities for interagency training, accountability, and shared resources*

The Community Transition Guide in Missouri:

The purpose of this guide, developed by the transition team in St. Louis, was developed as a tool to assist teams in the transition process for individuals moving from the habilitation centers to community life. The guide provides detailed information about the *requirements and process of transitioning* in Missouri and describes the roles and responsibilities of the transition planning team.

Transition teams have the option of utilizing this guide which is also available on the department's website.



A vision for the future:

When a person is in transition, this means change. Each time we plan with someone, we should seek ways to develop a vision that should ask the person and his/her team: Where does the person want and/or need to be 30 days from now, 60 days, 90 days, 6 months, 1 year, 3 years from now, etc.? It may take that long for long range goals to become a reality.

A person may not articulate what they want for their future; therefore, the job of the team is to find the best "informants". Those who know and care about the person may need to make their "best guess". In order to develop future planning we need to understand what is most important to the person. The team needs to also identify the support needs, obstacles, health, safety and risk issues for the person. Outcomes and action steps should be directed toward reaching the vision.

Consider the following examples of statements that should not only be included in the plan but should lead to "future planning" outcomes and action step or long range goals outlined in her plan.

- Jennifer and her family's goal for the future are for Jennifer to move into the community from the habilitation center by May of 2005.
- In the next few years, Jennifer will approach her dream of moving from the group home to living in her own apartment with 2 other people.
- Jennifer and her family wish to pursue Jennifer moving out of the family home within the next year. They are interested in seeking all available options.
- Jennifer would like to find employment other than the workshop.
- Jennifer would like to plan for retirement from the workshop by December of 2005.
- Jennifer would like to save her money to plan for a vacation for the summer of 2005.
- Jennifer's family would like to pursue a change in guardianship from her aging father to her sister who lives in another state.

EXAMPLES

The following pages provide examples for each section of the guidelines:

I. PERSONAL PROFILE

A. Demographic page
B. Documenting contributors
C. Who is important
   Relationship map or narrative format
D. What is important (including transitions and vision for the future)

II. SUPPORT SECTION

A. In everyday life – basic needs
B. Communication
C. Health needs
D. Environmental / safety needs

III. REQUIREMENTS OF FAMILY OF MINOR CHILD OR GUARDIAN

A. Relating to "what is important" section or
B. Relating to "support section"

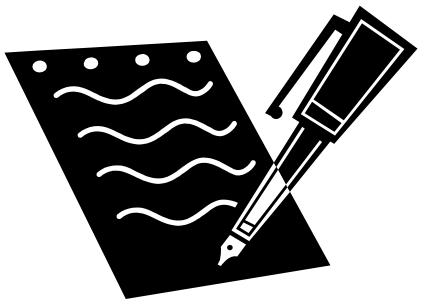
IV. ISSUES / CONCERNS

V. ACTION AND OUTCOMES

A. Defining action planning components
B. Different perspectives: using what makes sense (what's working), or doesn't make sense (not working) to develop outcomes
C. Examples for each component: outcome, current situation (or justification), action steps, strategies, measuring for success.

Personal Profile:

DEMOGRAPHICS CONTRIBUTORS



Example 1: Sample Demographic page:

AAA REGIONAL CENTER

WAIVERED CLIENT: ☒ **NON-WAIVERED:** ☐
NORTH: ☒
SOUTH: ☐ **SERVICE**
EAST: ☐ **COORDINATOR:**

NAME: Sharon Doe **DATE OF IMPLEMENTATION:**
DMH I.D. #: 014-000000 **DATE OF ANNUAL REVIEW:**

DIAGNOSIS: **AXIS I:** No Diagnosis
AXIS II: Severe Mental Retardation
AXIS III: No Diagnosis

COMMUNICATION STYLE:

MEDICARE #:

MEDICAID #: 00000000

SOCIAL SECURITY #: 555-55-5555 **DATE OF BIRTH:**

CLIENT ADDRESS: **COUNTY:**

CLIENT PHONE:

CONTACT/FAMILY:

CONTACT/FAMILY ADDRESS:

CONTACT/FAMILY PHONE:

GUARDIAN: **COUNTY:**
GUARDIAN ADDRESS:
GUARDIAN PHONE:

AGENCIES PROVIDING SERVICES	INITIATION DATE	REASON FOR SERVICES
ABC Regional Center	09-02-2003	Service Coordination
XYZ Services	12-10-2001	Residential Habilitation
ABC Industries	2-15-1995	Sheltered Employment
YYY County Board of Services	2-15-1995	Transportation

Example 2: Contributor / Sign-in sheet:

The contributor / sign in sheet is a way to document the contribution of information and/or attendance all of the people who know and care about the person. The intent is to ensure that all those important in the person's life are provided an opportunity to share information for the development of the plan even if they do not attend the meeting. Information gathering from others can be done by phone, questionnaire, meeting in person other than the plan meeting date, etc.

NAME:	**I.D.#:**	**DOB:**

PLANNING TEAM MEMBERS: (The following individuals provided input into the development of this plan).

NAME	***TITLE/*** **RELATIONSHIP**	**AGENCY**	**DATE PERSON PROVIDED INPUT**	**ATTENDED MEETING?**	**SIGNATURE**

Personal Profile:

RELATIONSHIPS

NETWORK OF PERSONAL RELATIONSHIPS AND VALUED ROLES

Missouri Quality Outcome #2: "People have a variety of personal relationships".

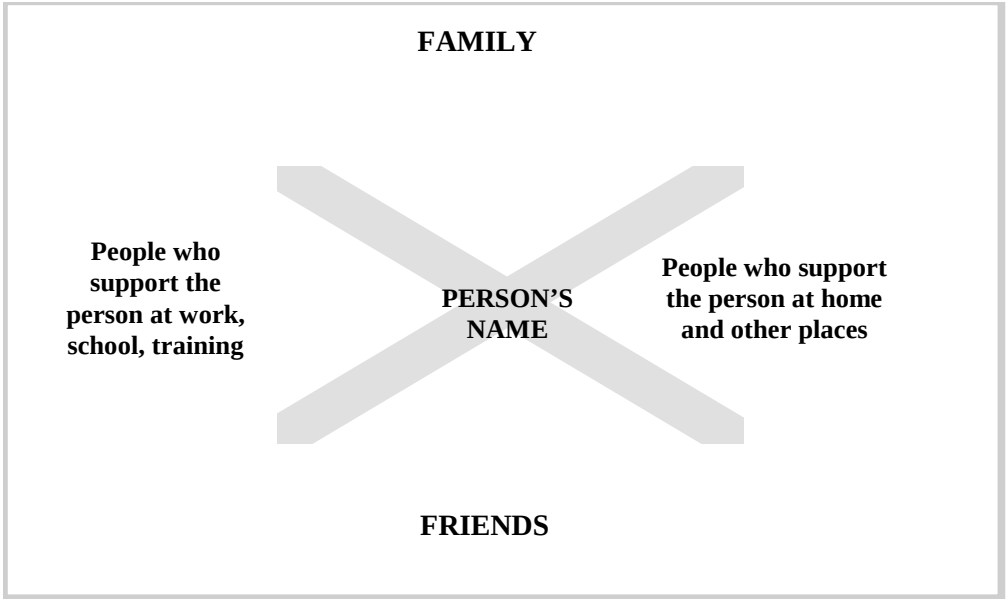
Many people feel that the key to a quality of life rests on relationships with others. Friends, family, neighbors, and acquaintances are important people in our lives. To be valued as a family member, for example, brings family fun, friendships, love and bonding. This includes relationships we develop in familiar places where most of our time is spent with coworkers, classmates, our partners, teammates, housemates, etc. Sometimes a staff person becomes a long term friend to someone they support but it is also important to support the development of diverse relationships with a variety of people. By doing this we can also assist individuals to develop shared experiences, gain access to social organizations, and participate in other "typical" community activities.

Relationship building is essential in person-centered planning because people with disabilities have been at risk of being unseen, segregated and alone. In describing relationships in the plan, this could assist the person and his/her team to look closely at personal networks. We need to determine if there is a possibility to increase opportunities for a person to maintain an existing relationship and to begin a mutual exchange for new social networks in their community.

"We need to belong intimately to a few people who are permanent elements in our lives. A life without people, people who bond with us, who will be there for us, who need us and whom we need in return may be rich in other terms, but in human terms it is no life at all; only our relationships with other people endure."

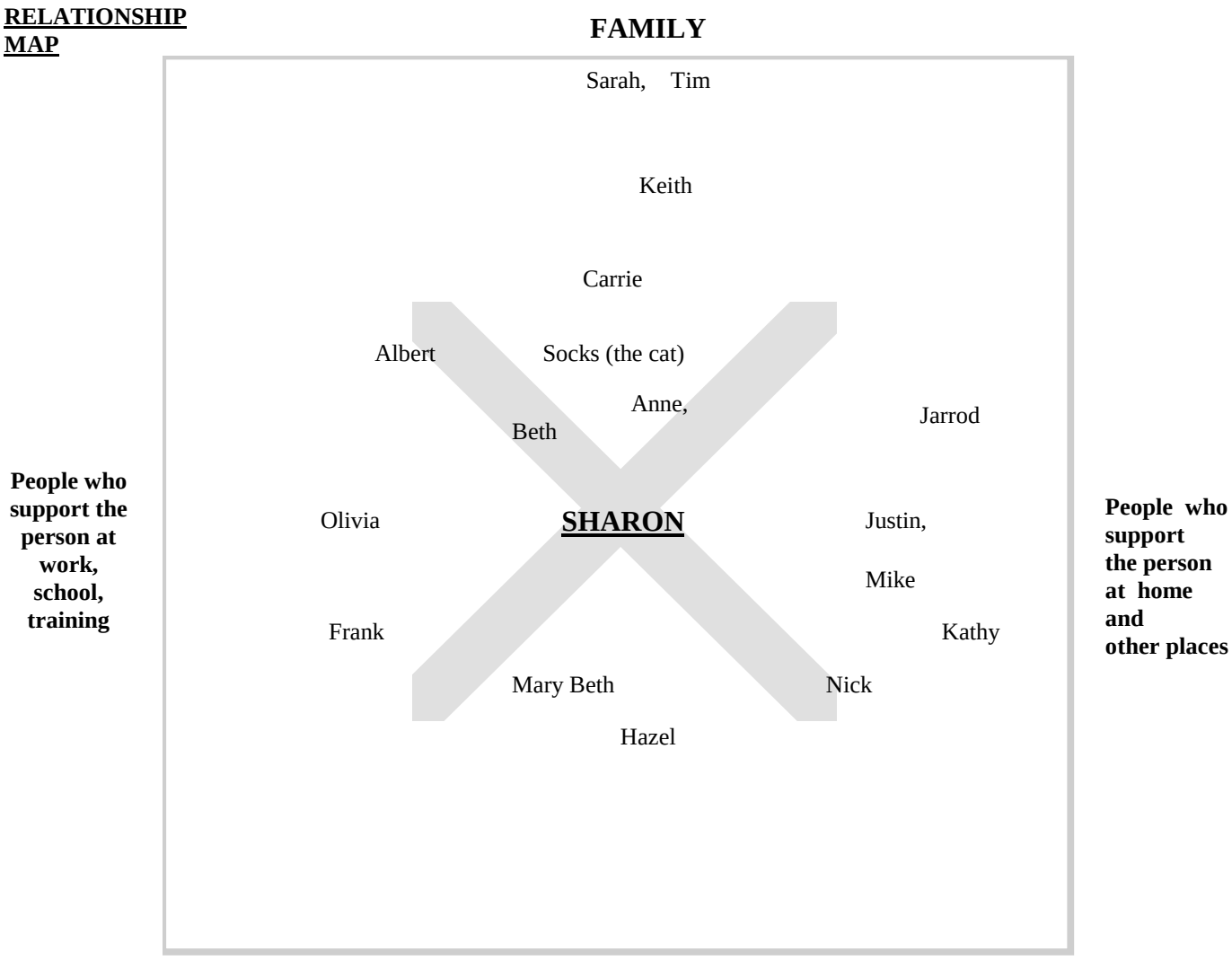
*(*Harold Kushner, "When All You've Ever Wanted Isn't Enough")

Example 3: Relationship Map A



Example 4: Relationship Map B

Example: "Sharon"



THE PROFILE

Example 5: Relationship Map C
"Sharon" in narrative

Sharon has been living in Kansas City since she was 12. Originally she lived with her mom and guardian, Carrie, two older sisters, Anne and Beth and her younger brother Tom. Sharon is very close to her mom, Carrie. Carrie calls every weekend and never misses a birthday or major holiday. Sharon's parents divorced when she was 10. This was very difficult for Sharon. Sharon's dad, Keith lives in Kansas City. Her dad is still very involved in her life and continues to have frequent contact with her. Sharon's dad calls at least twice a month and sends letters, cards and gifts on special occasions. Sharon's favorite is the "balloon bouquet" she receives from her dad every birthday.

Anne is Sharon's sister and lives in Columbia. Anne works during the day, has 2 children. Sharon loves her niece and nephew, Sarah (12) and Tim (19). She has many pictures of them in her home, but would like more pictures for her wallet. She enjoys showing off the pictures of her family and would like others to take the time to talk with her about her family. Tim, the 19 year old, attends college out of town; therefore, he and Sharon do not have much contact. He sees Sharon for most major holidays.

Since Sharon does not read it is very important that staff take time to read letters from family. If Sharon knows a letter has arrived in the mail for her and staff don't take time to help her, she becomes very upset. She may yell and hit the walls to show her frustration. Staff is expected to STOP what they are doing to help Sharon with her mail!

Holidays with family are usually celebrated at either Beth or Anne's home. Sharon's mom always makes sure Sharon attends family celebrations. People who know Sharon say that if she does not see or speak to her family frequently (at least once a week according to her mom), she will become upset. For example, people who know Sharon may notice her paying less attention to her appearance, arguing with her housemate more often or having sleepless nights. Sometimes staff needs to initiate a call to Carrie. Sharon just needs to hear her mom's voice and this usually helps when she becomes frustrated.

Sharon has a cat named Socks. Being able to cuddle with Socks really helps Sharon when she becomes upset. Sharon learned to care for Socks this past year. She knows when to feed him. She learned what it means to have pet vaccinations done and how to take Socks to the Veterinarian when needed. Sharon enjoys taking Socks to PETWORLD to buy food and toys. It is reported that the employees at PETWORLD recognize Sharon as a regular shopper.

Other important people in Sharon's life include her friends from work, Mary Beth, Hazel, Nick, Cal and Anna. They don't visit much after work hours but often see each other during dances and holiday parties. Sharon likes her supervisors, Olivia, Albert and Frank. Olivia is known to be very supportive and keeps in touch with Sharon after work hours.

Example 6: Relationship Map D in narrative - continued
Joan's personal plan - using headings to describe relationships

Some of the PEOPLE who are *MOST* important to Joan

➢ FAMILY:

Peter – Joan's **brother and guardian**. Joan says she also calls him "little brother". Joan sees Peter on weekends and holidays and calls as often as she "feels like it". When she wants to visit, she says she just makes a phone call, usually visits for at least one weekend per month.
Jenny – sister-law and **wife**.
Jim – brother, Joan usually sees Jim when she visits John, especially on special occasions such as Easter, Christmas and Thanksgiving. **Jenny – sister-law** and **wife**.
Juanita - wife of Jim
Uncle Dean – Brother of Joan's father
Helen – sister who lives in Ohio. Joan says she never sees her sister

** Joan's parents (Lil and Joe) are deceased.

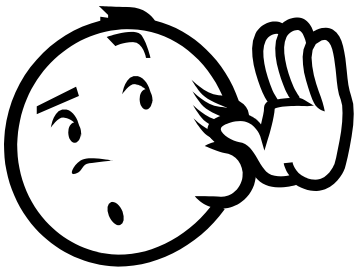
➢ **FRIENDS:**
Charles – Also known as "Chuck". Joan considers her best friend and sometimes her boyfriend. Joan has known Chuck for 5 years, and they also work together.
Louise – Best friend and shares her home and expenses. Joan has known Louise for the past 4 years. They have shared their home together for the past 2 years.

FRIENDS from workshop
Mike, Ron, Rick, Don, and Sylvia

PEOPLE WHO PROVIDE SUPPORT INCLUDE:
Linda: Workshop Supervisor – has known Joan for the past 6 months. Linda says Joan is a dedicated worker.
Kate: Agency Director – has known Joan for many years. Kate says Joan is witty and has a smile to light up a room. Jake**: Kate's husband, has known Joan for many years, as well. Jake says Joan is a real comedian!**
Darrell: Agency QMRP – has known Joan for the past 2 years. Darrell says Joan is a good friend.
Rebecca: Serv. Coordinator – has known Joan for about one year. Rebecca says Joan is fun to be around.
Jean– Jean is Joan's therapist and has known her for 1 year. Jean says Joan is intuitive and sensitive to other's feelings.

Personal Profile:

“WHAT IS IMPORTANT”



Person-Centered Thinking = People First Language

The profile: "What is important to know about Sharon" sometimes called "Who is Sharon" provides basic information that could include where she lives, works, how she spends her days, who she spends time with (relationship information/map), her history, ways in which others respectfully describes her, her interests, preferences, capacities, things she'd like to do, try or learn, etc.

The purpose of this information is to give an unfamiliar reader a sense that they have just been introduced to the person, to provide a "snapshot" of the person's life. We need to remember the importance of the language we use to describe people. Remember that historically, the language generally used to describe a person with a disability were words that labeled, stigmatized and defined deficiencies. The words we choose to use can reflect the thoughts and opinions of those we write about.

One of the characteristics of person-centered values is the use of everyday, respectful language:

Tip: Talk TO people and families, not AT them. Use "people first" language. Ask "did I get it right?" Pay attention to the cues of "non-traditional," ("non-verbal") language. Don't talk down to people; watch your tone of voice and body language when communicating.

Yes, it is possible to describe issues and concerns without being degrading, or disrespectful to the person. We should also minimize the use of "human service" terminology so that anyone reading the plan can understand its content and intent (i.e.: the person, family members, staff, or anyone else who are not familiar with "system" jargon, etc.).

Tip: Avoid the use of words like "low-functioning" "high functioning", "non-verbal", "non-compliant", "displays inappropriate social behaviors", etc. Instead be as specific as possible, Make sure you balance this information by describing the capacities of the person and specifically define the person's support needs. Describe the person's method of communication, how the person expresses his/her needs, wants, desires, frustrations, and social experiences.

Tip: Avoid describing the person as part of a group. For example, by merely stating the person has cerebral palsy doesn't mean the same for all people. The support needs of one person with cerebral palsy may be very different for another.

We should never hide or "sugar coat" important information that could have an impact in the everyday quality of life for an individual. Health and safety issues must always be shared to ensure the health, safety and well being of the person, those who support the person and community members. It is often difficult but we must **find a "balance"** when sharing important issues in a person's life while being respectful to the person. Information about a person from the past should never be used as a means to label the person when time still needs to taken to get to know the person first especially by new staff. However, historical information can help us to gain a better understanding of the person and to figure out the best way to provide the right supports / services.

"Never become overwhelmed by the endless assessments and professional opinions, stay focused on who the person is, and never loose sight of the fact that first and foremost, we are talking about people's lives……."

(A. Schouten, Parent, excerpt from "A Service Broker Can Make A Difference", Nat'l Program Office on Self-Determination)

Example 7A: "What is important" section of the profile

Who is Sharon?

Sharon is an outgoing 33 year old lady who lives in the south part of the metropolitan area. She shares a rented home with one other person, who happens to be a good friend. They have been living together for the past 3 years. Sharon receives services/supports through XYZ residential services since January 1999 through the individualized supported living program.

Those who know Sharon well describe her as sociable, entertaining, fun to be around, loving and committed to her family. Sharon is fairly easy going but also very routine oriented.

When Sharon moved from her mother's home, Sharon has adjusted well to her environment. Over the past several years, Sharon has taken great pride in her home and her appearance. She doesn't enjoy house chores but she does enjoy the benefits of having her own place and space for everything she owns. Sharon has many possessions (mainly from her giving family) and likes to keep everything organized. She especially takes pride in her relationships with others and likes sharing her pictures; this is Sharon's way of having conversation and getting to know someone unfamiliar.

Sharon does not use many words to communicate (see communication section of plan). However, she does express her needs, wants and desires and clearly lets you know when she is having a bad day. It has been discovered that music, socks (her cat), and phone calls from her mother on a regular basis and her pictures of loved ones helps with maintaining good days.

Sharon works part time at ABC Industries and has been working there for the past 10 years. Since the year 2002, Sharon appears to be easily distracted and bored at work. She has been described as a good employee over the years but the team feels Sharon is loosing interest in the workshop setting. Sharon also enjoys the benefit of working by her excitement over receiving her small paycheck every other week. The team along with the workshop staff supports Sharon to explore other options. Sharon's team is attempting to contact vocational rehabilitation (VR) to seek supported employment options. In the meantime, the workshop agrees that if Sharon could work part time may be the best option. Sharon has been part time for the past 6 months; and appears to be a much happier, outgoing person.

Example 7B: "What is important"
Sharon's personal plan profile - Using heading and bullet points (another formatting option

"What is important to Sharon"

- Sharon enjoys music such as Gospel and country. Her favorites are Garth Brooks and the Dixie Chicks. Sharon enjoys her music especially when she does chores around the house.
- Sharon is also a sports fan. She enjoys baseball (favorites are the Royals) and football (the Chiefs). She enjoys having someone to "talk sports" and she especially likes to stay current on games and information about players, as well.
- Sharon is considered to be athletic. She enjoys playing softball (she is a member of her church softball team). Sharon also enjoys bowling, walking with her roommate and staff and has fun exercising to tapes like Richard Simmons.
- Cooking and helping in the kitchen: Sharon enjoys cooking and would like to lean to prepare different types of dishes.
- Enjoys barbequing for herself and for her friends: Sharon owns a George Foreman grill and has learned to cook hamburgers and brats with assistance. Sharon is a real hostess! Sharon's nephew, Tim was so excited to hear her interest in learning to cook; he purchased the grill for her birthday.

Regarding routine:

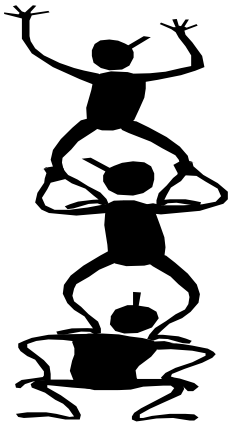
(Note: Sharon is very routine-oriented but she works well with changes as long as she is informed that her regular schedule may be interrupted).

- Sharon works 3 days per week at ABC Industries Workshop.
- A typical weekday for Sharon begins at about 7 am: Sharon does not like to get up early! She showers immediately. The shower helps her to wake up and to "get-going" in the morning. Sharon should never miss taking her shower in the morning.
- Sharon eats a light breakfast, usually toast, cereal or fruit. She can prepare this herself and does so after she showers.
- She doesn't like doing dishes much, but will do it if reminded and while listening to her radio.
- She generally goes out for a walk (weather permitting) in the evening after work and in the morning on days she does not work. She returns home and relaxes for about ½ hour.
- She has lunch about 11:30. She enjoys peanut butter sandwiches, loves soup, Grilled Cheese and ALWAYS wants a glass of milk and water with her meal.
- After lunch she listens to music, does chores (like laundry or cleaning the apartment) or watches a game on ESPN.
- On days Sharon is not working, in the afternoon, Sharon usually goes shopping, pays bills, goes to the park, out to lunch once a week pending her funds, or runs other errands with her staff.
- Sharon and her roommate divide up the chores for the week. Sharon and her roommate generally have dinner together. On Monday evenings Sharon and her roommate (Mindy) are supported to make up the menu for the week. Staff supports them by suggesting side dishes, keeping within their budget and helping them look at sales items in the newspaper flyers. They both enjoy clipping coupons before grocery shopping with staff.
- After dinner, if Sharon has no plans to go out, she and Mindy watch movies, listen to music or play card games like UNO, etc. Sharon always says her prayers before going to bed. Sharon likes to go to bed around 10 pm and will do so with her TV on at a low volume.

Personal Profile:

SUPPORT SECTION

(What do we need to know, what do we need to do to support the person?)



IDENTIFYING SUPPORTS IN THE PLAN

The support section of the plan is a crucial component of the planning process. It is an area that identifies "how" the supports need to be provided. This information was already identified under what is important to Sharon. The support section describes:

- The behaviors of support staff
- Specifics about what works and/or does not work for the person
- The specific strategies or methods that helps the staff to understand health, safety, behavioral or risk issues for the person

Examples 8A-1 – (supports):

- *Make sure Sharon has an opportunity to shower in the morning before she goes to work.*
- *When Sharon is cooking using her George Forman Grill, never leave her alone, although she appears to be very independent, she often becomes easily distracted.*
- *Avoid settings that include large crowds. Sometimes talking to Sharon before an event that may include large numbers of people may help with her feeing some anxiety. Try it, but when Sharon says "lee now!", this is a sign of her feeling anxious, therefore, it's time to leave now!*

These are some examples that require understanding and listening to the needs of the person. The support section could also be a valuable tool:

- For new staff in orientation
- To match the characteristics of staff to the person supported
- As a learning tool for others who know think they know the person well
- When a person is experiencing some type of transition

Example 8A-2 - Other tools to use to describe supports:

When This Is Happening	And Jennifer Does	We Think It Means	And We Should
MEALS / EATING and DRINKING	• holds her cup up at you	• Jennifer wants more to drink	• Provide more to drink (usually water). Remember, Jennifer has NO DIETARY RESTRICTIONS for what or how much she drinks, she really likes water!
	• throws her cup down	• Jennifer has had enough to drink	• Respond by not giving Jennifer more to drink
	• goes straight to the kitchen	• Jennifer is looking for something to eat	• Accompany Jennifer to the kitchen; make sure Jennifer has a choice of snacks. She will respond by pointing to the snack she prefers. • Always provide opportunities to choose

Example 8A-3 - supports are embedded in "What is important to the person"

(This narrative also includes hints on "how to support" Sharon, instead of stating supports in a separate section).

Sharon enjoys helping in the kitchen although it is important that she have assistance from staff while cooking, as she might forget the burners are on or that something is in the oven. Sharon is often sidetracked if not reminded to check on the food. Sharon's favorite is cooking outdoors. Sharon enjoys BBQ and has learned to make hamburgers and brats on her electric gill. She really pays attention when using her grill. Her brother, Tim bought her a George Foreman Grill for her birthday with utensils and a red Chief's apron, which she wears with pride! She does need help setting up the grill. Sharon really enjoys having family over for BBQ. Sharon wants to learn to make more dishes in the kitchen and on her grill.

Sharon loves to listen to music. She especially enjoys live music, such as an outdoor concert. Sharon does not enjoy live music indoors such as a dance hall where she feels confined or experiences a feeling of being "closed-in". Her favorite music is gospel or country. She listens to Travis Tritt, Garth Brooks and the Dixie Chicks. Staff discovered that it is easier for Sharon to complete undesirable tasks around her home (such as cleaning, doing laundry) while she listens to her favorite music.

Sharon is also interested in Baseball (Cardinals and Royals, her favorite) and Chiefs football. Her roommate does not really enjoy these things and it is important that staff be able to talk with Sharon about current sports events. Sharon is known to be athletic. This year she played softball on a team through the youth league at her church. She really enjoys bowling, walking and exercising to her Richard Simmons tapes every chance she gets. Her friends Mary Beth and Hazel both play sports and are also fellow sports fans.

Sharon works part time, 3 days per week at ABC Industries. Sharon's goal is to someday seek a job elsewhere and her team is helping her to seek support from Vocational Rehabilitation. She has been referred this month. The team feels that the workshop environment does not benefit Sharon. She is capable for other types of employment. Sharon does not enjoy her work but does enjoy the benefits of working by showing excitement after receiving her small paycheck every 2 weeks.

On days Sharon is not working, a typical weekday for Sharon begins at about 7 am: Sharon does not like to get up early! She showers immediately, this helps her to get up and going in the morning. Sharon eats a light breakfast, usually toast or cereal and fruit. She can prepare this herself and does so after she showers. She doesn't like doing dishes much, but will do it if reminded and while listening to her radio. Staff should inform Sharon if she has any appointments for the day or any other event that will be different than her normal routine. If not, she generally goes out for a walk (weather permitting). She returns home and relaxes for about ½ hour. She has lunch about 11:30. She enjoys Peanut Butter Sandwiches, chicken noodle soup, and Grilled Cheese sandwiches and ALWAYS wants a glass of milk and water with her meal. After lunch she listens to music, does chores (like laundry or cleaning the apartment) or watches a game on ESPN. Sharon and her roommate divide up the chores for the week. On days Sharon is not working, in the afternoon, Sharon usually goes shopping, pays bills, goes to the park, out to lunch, maybe once a week, or run other errands. Sharon and her roommate generally have dinner together; they make up menus for the week, clips coupons, or play card games, etc. Staff supports the ladies by suggesting side dishes; assists them to stay within their budget and to look at sales items in the newspaper.

Example 8A-4: "What do we need to know or do to support the person?" Sharon's personal plan (refer to what is important to Sharon, basic supports)

(This example shows a separate section highlighting "how to support" instead of placing in the narrative that describes what is important). This information will provide all those who support her with information about her daily needs and what they need to know or do to make sure her daily needs are met.

Although Sharon can prepare some meals and snacks on her own, she needs support for safety reasons. When Sharon is cooking or grilling, she requires supervision, for now. She might forget the burners are on or that something is in the oven. Therefore, staff needs to pay attention. Sharon gets sidetracked when she has too many tasks to do at one time, therefore, simply remind her to check on the food etc. Sharon has shown to be more attentive when cooking on the grill. Make sure Sharon has only one task to do at a time.

Sharon does not like to feel closed-in and does not enjoy crowds of people in a confined area. Staff may need to talk to Sharon about an environment prior to the trip or provide her the time to get used to the new environment. Sharon will let you know if she is uncomfortable, such as yelling, or hitting things such as a chair, or any other object near her. However, be prepared to leave immediately once she says she needs to leave. When Sharon yells, "lee now!" (meaning: leave now!), don't spend time trying to talk her into staying. This will escalate her anxiety to leave. Staff reports that Sharon does enjoy outdoor concerts, irregardless of the crowds, therefore, you never know, just take the time to try it and respect her feelings once she expresses herself to you.

Sometimes Sharon will choose not to do her part when doing household chores. One thing that staff discovered, it is easier for Sharon to complete "undesirable" tasks around the apartment (such as cleaning, laundry) if her favorite music is playing. Start out by staying upbeat. Then, ask Sharon if she'd like to play a CD, tape or listen to her favorite radio station. Then, remind Sharon about the activities and responsibilities she committed to with her housemate. Say, "Sharon, together we can do _____ while the Dixie Chicks are playing".

When doing chores, it is very important to talk about things Sharon enjoys, such as current sports, news and events or just listening to music. Keep it fun, be talkative. This will help Sharon to look forward to the next task.

Example 8B: What do we need to know or do to support the person (to stay healthy?)
Sharon's personal plan

- Sharon enjoys exercising and is recommended by her physician to try loosing 15-20 lbs. Sharon often complains her legs hurt and tires easily. A consult with a dietician is recommended. Her physician also recommends that a low impact exercise regiment to help with weight loss. He is pleased that Sharon tries to walk daily but suggests that she might try increasing her distance by one more block. Various tests were completed during her physical on 1/15/04, to ensure no other problems were occurring. To date, no other concerns are noted. Sharon and her staff need to report to Dr. Jay, in one month, to follow-up on her progress. Sharon is NOT on a "special diet" but just needs watch her portions and to continue exercising as she does each day already.

- Sharon has eyeglasses but does not always wear them. It was initially recommended that she wear them as often as possible. She just started wearing them one year ago. During her last eye appointment on 12/30/03, there were no concerns or recommendations noted, her eyeglass prescription was adjusted slightly. Sharon just needs simple reminders when she is browsing through books or magazines, watching TV or going to the movies to wear her glasses. Also remind her that she helps her eyes to stay healthy when she wears them.

- Sharon takes the following medications: Depakote 250 mg for seizures although no seizure activity has been observed for at least 1 year. Staff continues to monitor and document as needed. Sharon also takes a Multivitamin daily and Colace (stool softener) 1 time per day, as needed. Sharon sometimes has problems with constipation. Her doctor says she just needs to watch what she eats such as adding more foods with fiber. Sharon is not on a special diet.

- Sharon's immunizations such as Hep B and her TB are current.

Example 8C: "What do we need to know or do to support the person (to stay safe)?"
Sharon's personal plan

- Sharon is not always safe when she is cooking in the kitchen. Sharon often becomes forgetful when working in the kitchen, or when a pot is on the stove. Sharon requires supervision when using kitchen appliances such as the stove or oven. (Sharon can use her toaster and microwave on her own). Supervision is required in the kitchen anytime Sharon attempts to prepare a snack, or her lunch for work, etc.
- Sharon often wants to cook a meal using the stove on her own at any given time. Sharon needs constant reminders about the importance of using the stove and oven safely.
- It is important to explain that part of learning requires staying safe and that this will help prevent to fires.
- It is important to know that 6 months ago a small kitchen fire was the result of staff forgetting to supervise Sharon while cooking dinner. (This will be an on-going support need and an outcome to reflect learning safety).

Example 9: Requirements of family of a minor or guardian

Sharon's personal plan

What's important to Sharon's guardian (Carrie?)

- Make sure Sharon lives in a safe neighborhood and shares her home with someone who is compatible such as her current housemate

- To be notified anytime there are issues or concerns. Although Sharon has been fairly healthy, Carrie wants to be sure she is notified of all doctor recommendations or any medication changes. Carrie says a simple phone call, or note will do. Carrie can also be contacted on her cell phone; the QMRP and Service coordinator has access to this number.

- Carrie requests that Sharon's siblings are also invited to the annual meeting. Carrie requests to be notified about all other meeting such as addendums, or monthly meetings. She will do her best to work within her personal work schedule to attend. Advance warning (at least 48 hours) helps her to work out her schedule.

- Carrie states she will notify Sharon's dad so that he too could participate, however, he is usually not available.

- Carrie requests that staff supervise Sharon at all times when using appliances in the kitchen due to an emergency call several months ago resulting in a small kitchen fire. Carrie supports Sharon learning independence in the kitchen but wants to be sure Sharon is safe at all times. She requests to be informed of Sharon's progress towards learning safety skills and what to do in an emergency.

- Carrie requests that Sharon's plan emphasize learning safety skills and that NO ONE STAFF PERSON decides when it is safe for Sharon to cook on her own, but to instead make sure it is agreed upon as a TEAM DECISION.

- Carrie requests to be notified for any and all changes to the person-centered plan. Addendums are not to occur without her prior approval.

Personal Profile:

COMMUNICATION

THE IMPORTANCE OF COMMUNICATION:

Missouri Quality Outcome #5: "People's communication is understood and receives a response".

Missouri Quality Outcome #6: "People are provided behavioral supports in positive ways".

To support others in learning skills of self-determination, individuals must be well grounded in listening to and understanding human behavior. Comprehending the underlying functions of human behavior is critical to being able to adequately understand others. It must be understood that all human behavior is purposeful and goal-oriented, although the purpose(s) or goal(s) of each behavior may not be readily perceived. Actually, it is quite easy to misperceive another's purpose or goal. Understanding the many factors which influence human behavior and the way that behavior generally tends to present itself will guide one into greater understanding of others. The learner can begin to "listen" not only to words and body language, but to the actual behaviors engaged in for the "message" behind those behaviors. (Missouri Community Network Curriculum- May, 2001)

We all need a reason to communicate. Most individuals express ideas, feelings and desires through words, gestures and body language to convey messages and respond to others in their environment. A person must be able to understand what is being communicated and a means of communicating back is also needed. This may require training in language acquisition and/or in the use of an augmentative communication device. Individuals' environment should promote the desire for conversation.

Some individuals have difficulty communicating, therefore behavior can often inform us how they are feeling or thinking. Alternative methods for communication should be available in all environmental settings. We should always ask questions about what each person's behavior may be communicating.

When unacceptable interactions occur, attempts should be made to understand the person in terms of communicative intent/function and the variables that are contributing to its presence.

Person-centered planning is a process that promotes learning and understanding a person's individualized support needs so that personal life goals are achieved.

Example 10A: What is important – Understanding how the person communicates using the "communication chart"
Chart format - Kate's personal plan

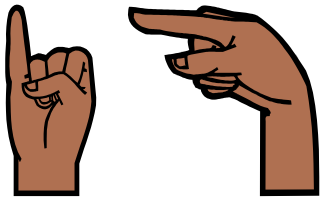
How "Kate" Communicates

What is happening…	Kate does this…	We think it means…	And we should…
Kate is in emergency room or doctor's office	Hits, grabs, flings arms and legs about	Kate is scared	• Give Kate paper to play with • Read and show pictures in magazine
Kate is walking with support	Sits downs	• Kate doesn't want to go where you are taking her • Kate is afraid of falling • Kate is tired-back hurts	• Ask her to show you where she wants to go • Hold her more securely under her arm • Sit down with her for a rest
Kate is sitting in a chair	Gets down on floor and lies down	Kate back is tired of sitting up	• Support her to walk around a bit • Find an appropriate place for her to lie down awhile
Kate is eating	• Turns her head to the side • Hands you her spoon • Makes "The Mouth"	• Wants no more food • Feed me • I need to burp	• Put the food away • Wait until she has burped or belched before she eats more
Kate is out shopping, eating in restaurant, or is in any place where there are people her age	Has a smile on her face and reaches out to touch the arm or take the hand of a young woman Acts flirty, giggly, or coy around a young man	Hello, I want to spend some time with you I like your looks! Want to be friends?	If possible, say "hi" to the person and introduce Kate Same as above

Example 10B: Chart format – Sharon's personal plan

When this is happening…..	Sharon does this….	We think it means…	And we should……..
At any time	Points to her pictures	Sharon wants you to look at her pictures	• Take a few minutes to look at her pictures • Ask questions, Sharon can say, "yes/ no"
Usually at bedtime	Starts crying and shows no interest in interacting	She is sad and misses her mom	• Try encouraging Sharon to look at pictures of her mom and talk to her • Call her mom (she has given permission to call her at any time Sharon or staff needs to speak with her)
In a setting where there a lots of people	Yells: "lee now" Meaning "leave now"	The environment is a little too crowded for Sharon at that time	• Talk to Sharon, say: "ok we will leave now" (don't try to talk her into staying longer). Say: • "Sharon, may I look at some of your pictures?" Then talk about the pictures while preparing to leave immediately or as soon as possible.

Example 10C: What is important – "How the person communicates" – continued



Anne's communication style:

- Anne had a communication device that she no longer uses because it is large and cumbersome. She showed no interest in using the device due to its size, and difficulty in programming it. The device was used when she was in school, and required repairs.
- It is documented that Anne once used American Sign Language while in school, but forgot many signs or chooses to no longer use sign language.
- Staff is still learning about Anne's communication style and may need to make guesses before getting it right.
- Anne now has a communication book with photos of favorite people and places. She is encouraged to use it as often as possible. It is also observed that Anne does not appear to like using any device to communicate. It is believed that Anne prefers to use words to communicate although it is not always easy to understand the few words she uses. Sometimes Anne prefers NOT to talk at all!
- Anne will usually respond to yes / no questions by nodding her head. She also understands simple signs and may sign the word "no". Anne also uses the sign for "bathroom", and signs "go" when she wants to go places.
- Anne may also "grunt" when answering a yes or no question.
- Anne may also pull or "tug" on a person's arm to communicate a need.
- When Anne is having a bad day, those who know her well say her forehead "wrinkles", therefore, looking as if she is "shutting down." If this occurs, try offering Anne a snack, or distract her with something she enjoys such as a video, card game, sitting on her porch rocker, weather permitting.
- Anne may place her fingers or palms over her ears, or pace. It is suspected that she is "hearing voices".
- Anne may also place his palms over his ears when he is tuning out certain people or paces when he is bored or restless.
- When Anne paces, we think it means:

She is either bored and needs to be involved in something that interests her.
It could also mean she wants to go places (i.e. leave the room, or a building, or situation, etc.).

- Anne does not <u>verbally</u> express her needs but she definitely understands what others are saying and enjoys your attention by listening or sitting in on conversations.

Personal Profile:

ISSUES / CONCERNS

Example 11

Issues to be resolved / concerns section:

NOTE: This information can also be effectively conveyed in the "what's important" section, or "what's working/not working" section (also known as what does or does not make sense), or in the person's communication chart, etc. Just remember, if this information is identified in other areas of the plan, it is NOT necessary to repeat in another section of the person's plan.

This section can be used to identify a wide range of issues that have not been resolved and continue to be a struggle for the person, family and team. There may also be situations where people cannot come to an agreement, but do agree to seek to find a resolution. This could also be the place to define behavioral issues or concerns relating to health and safety issues (if not listed in the support section for health and safety).

When identified in the plan there must be an attempt to revisit the issue for resolution. This information can and should come from a variety of perspectives: the person, family / guardian, or staff regarding quality of life and support issues. THIS IS NOT THE PLACE TO LIST AGENCY ISSUES PERTAINING TO MANAGEMENT, PERSONNEL, ETC. The team should also use this information as a basis for gathering MORE information and to brainstorm ways to implement change. This information should lead to a plan of action or future planning (to develop long range goals to address unresolved issues).

The guidelines provide a list of situations in which this section could be helpful, for example:

- The person wants one thing and the guardian wants another. (E.g., the person may wish to move back home, but the family does not want this to happen.)

First, the team needs to develop a shared understanding of the situation. The place to begin may be to gather additional information from the person, family and all others who know and care about the person. A team gathering may be necessary to resolve the issues. The team should be asking questions a means of promoting resolution and action:

1) **Do we understand why Jennifer wants to live with her family?**
2) **Do we understand the issues as to why this is not an option?**
3) **Are there issues between Jennifer and her housemates, staff, etc? that causes her to want change?**
4) **Why Is Jennifer unhappy in her present living situation?**
5) **How can we support Jennifer to make an informed choice?**
6) **What are other alternatives that Jennifer and her family can agree to?**

Once the questions are answered, the action plan then needs to be a means of identifying (with the person, guardian, and the team) where to go from here.

Personal Profile:

ACTION PLANNING
&
THE MISSOURI QUALITY OUTCOMES

Tools:

- **What does / does not make sense, or what's working / not working?**
- **What needs to be maintained, changed, and/or enhanced?**
- **Looking at issues / concerns**
- **Valued roles**
- **Transitions**
- **Career outcomes**
- **Vision for the future**

A word about ACTION PLANNING:

Overview:
The decision making we make in our own lives often results in a plan of action. This only means we too make plans, short and long term, to achieve an important goal. We may also need to take "baby steps" before we reach each goal and we may even need a support strategy along the way.

Far too often, promises are made to the people we support with little follow through. Plans are developed, we write it down, but then, it's like the clock stops ticking. Somehow the rest of us move on but the person keeps waiting, and waiting and waiting for change.

Action planning is not a new process because we use it in our own lives, perhaps informally. It ties back to what is important in our lives. By formalizing this process in our work, we must take the time to ensure that no matter who supports the person, the efforts should never stop and the person should not have to wait on us to catch up when he/she has been waiting, waiting, and waiting for quite some time for things to change. Development of the action plan means *commitment, consistency, accountability, and implementation* to reflect all the hours of listening, learning and understanding the person's needs, wants, desires, interests, preferences and capacities.

- *Commitment* = to gather information, to have a shared vision, decision making as a team effort, a promise to make the plan happen.
- *Consistency* = no matter who, when, or where supports are provided, the action plan will ensure supports / services are delivered in a consistent manner, information will not get lost and outcomes are implemented in a way that makes sense to and for the person's needs.
- *Accountability* = responsible person(s) for making sure the outcomes are happening in the person's life.
- *Implementation* = synthesizing the information gathered, putting the plan into action, tracking progress, assessing what does or does not work, an on-going cycle of listening and learning about the person.

Using the Missouri Quality Outcomes to develop outcomes in the person-centered plan:

Plans must be written in accordance with the Missouri Quality Outcomes to ensure opportunities for quality of life. They reflect best practice, and provide us with a look at outcomes that define a typical lifestyle desired by anyone. Although the outcomes provide us with examples of how they can be defined, the definitions are NOT standard. We all could have the same outcome, but may define it differently depending on our current situation, life experiences, and future goals. The steps each of us takes to reach the same outcome may be distinct by our own personalized paths or journeys. For example, the Missouri Quality Outcome that states: "People belong to their community" will be defined differently for you depending on where you live, who you know, what you want from the community, what you want to contribute to your community, and the resources available to access your community.

By using the Missouri Quality Outcomes in the process of person-centered planning will assist the person and his/her team to seek ways to enhance and/or offer opportunities for a better community life, to develop valued roles and to implement action and outcomes that makes sense specific to meeting the person's needs and preferences.

Note: When utilizing the Quality Outcomes as a means to develop personal plan outcomes, the plan facilitator must understand the purpose, intent and values of the outcomes in order to successfully facilitate the action planning process. *Please see the Missouri Quality Outcomes introduction section that outlines the general purpose, values and assumptions.*

Example 12A: ACTION PLANNING COMPONENTS:

a) **Outcome statement** – always reflects what is important *to and for* a person, what's working or not for the person, etc.

A few words to describe an outcome include: the result, or the "big picture." Points to remember:

- An outcome IS NOT a service or service definition such as "will receive residential habilitation". The result is not the residential habilitation but **how** this service impacts the person's quality of life.

- An outcome IS NOT a statement for continued services, such as, "will continue to receive 24 hours support from staff", "will continue speech therapy from school"

- An outcome IS NOT the action step. *Services represent action taken as a means of reaching the outcome*. The purpose of *action steps* is to define what it takes to make the outcome a reality!

b) **Criteria** – How do we know when the outcome is accomplished? Criteria simply mean we have the information we need (from staff observation, documentation, and information from the person, family and others' perspective) that tells us the person has met either the outcome as a whole or the specific action step within the outcome. Quality of life goals are often subjective; therefore, good, detailed documentation for each action step is the key to determining outcome or action step completion.

c) **Current situation:** Justifies the need for the outcome. Ask: "Why does the outcome exist?" It is a short statement that justifies the need for the outcome. It is a good opportunity to again, emphasize the need.

d) **Action Steps:** (otherwise known as "objectives"): These are ACTIVITIES used to define each step one must take to reach the outcome. The action step defines the criteria needed to complete the step.

e) **Strategies:** Where there is an action step, there should be a strategy. How would a staff person know how to implement the outcome / action steps without providing them with the strategies for teaching the person, how the person learns best, documentation requirements, etc? This should be the information staff will need to understand agency expectations to implement the person's action step.

f) **Accountability:**

- Names of person(s) responsible: This is up to the team, but there needs to be someone named as the responsible party for the implementation of each action step.

- Timeline for completion: As best practice it should provide the timeline for when the action step will be implemented because all action steps need not implement at the same time. Action steps should only be implemented for the time the person and the team feels it will take to implement and complete. For example, it does not make sense that an action step for obtaining a state ID will take from March 31, 2004 to

February 28, 2005. This action step should only take as long as it takes to set up the time and transportation for the person to accomplish this task; maybe 1-2 weeks or less?

Example 12B: ACTION PLANNING

Use **profile** information to assess what needs to be maintained, enhanced, changed or different (also known as what does or does not make sense, or what's working/ not working) to begin developing action.

	What Makes Sense **What works? What needs to be maintained/enhanced? (The upside right now.)**	**What Doesn't Make Sense** **What doesn't work? What needs to change? What must be different? (The downside right now.)**
from **Sharon's** perspective: **Best Guess**	Having family care about her Having her friend as her housemate Having pictures of family and friends to share with others Having a pet , (socks her cat) Having someone to spend time with AND spending time alone when she wants to Working part time and making some money Listening to music while doing chores	Places where there are crowds of people or NOT being told this may happen Going to the workshop even if it is 2-3 x per week Crying and missing mom so much NOT using her pictures to initiate conversation with others When staff say they don't have time to talk or look at pictures
from **Staff's** perspective:	Sharon's family support Sharon's mom always seems available Having staff who appreciate and respect Sharon's communication Sharon's home, the location and her housemate Pictures, and recliner/rocker seems "calming" Keeping family informed Keeping a busy schedule	Don't understand why in some places crowds of people are a problem and other times it is not Not always sure why Sharon gets "agitated' Sharon's dependence on mom Sharon's abilities outweigh what she actually learns – Capable of more independence (like in the kitchen) and need to utilize Sharon's talents. She is sociable but only socializes with her family and staff, not friends outside of work.

Note: This could also be a place to share the parent/guardian perspective if not identified in other areas of the plan. The following items should /could be addressed in the "what we need to know or do to support Sharon":

- How to support Sharon in the community when there is a potential problem – such as being around "crowds" of people. However, the staff may need to gain a greater understanding of Sharon's support needs by conducting a "functional assessment" to better understand why she responds in a certain way, with certain people at certain times.
- What to do when "we think" Sharon misses her mom, maybe alternatives to calling mom.

The following items should / could be addressed in the action plan:

- Seeking meaningful work
- Facilitating and enhancing communication in a way that makes sense for Sharon
- Learn safety skills in her home so that independence in the kitchen can be enhanced.

Example 12C: ACTION PLANNING, continued

Step #1: Assess what does / does not make sense (what's working or not), which reflects the information from the personal profile; this takes us to step 2. See previous page with example.

Step #2: Developing the outcome and rationale - (Note: the "rationale" is also referred to the "justification" or "current situation")

Quality Outcome: *Sharon's communication is understood and receives a response.*

Sharon's definition of the outcome: *I want to talk to others using my pictures.*

Current Situation: *Sharon currently uses few words to communicate and is usually understood by staff. Sharon wants and needs a way to communicate with people she does not know especially if she obtains a new job. Sharon likes to use her pictures to initiate conversation with others this is her communication style.*

These are the services that will help to implement the outcome.
Service(s): Residential Habilitation, XYZ Services
Off-Site day Habilitation, XYZ Services

Step 3: Developing Action Steps – (Ask: what needs to happen to make the outcome a reality?)

Step 4: Support Strategies (also known as learning strategies to some).

Action Step #1: Develop a communication book.
Implement by: 4/1/04,
Estimated completion date: 6/1/04
Responsible person(s): Sharon, Kathy (staff), and Justin (QMRP)

Strategies:

- Sharon, with support will develop a list of people, places and things to begin her communication book by 4/15/04. Contact family by 4/5/04 for ideas, go through existing pictures to be used, may need to get extra copies made by 4/10/04.
- Sharon, with support will budget her money to purchase a disposable camera and wallet of her choice to take pictures of her favorite people, places and things by 5/1/04.

Example 12D: ACTION PLAN WORKSHEET USING MISSOURI QUALITY OUTCOMES - **(J. Wyble outcomes trng. – 4/03)**

Missouri Quality Outcome:	*Jennifer has a variety of personal relationships.*
Current Situation (Justifies the need for the outcome):	*Jennifer does not see her family as often as she'd like. She hears from her mother and brother by phone and on major holidays. Jennifer, her mom and brother would like more contact but need support to make this happen. Currently, support staff makes informal calls to the family to stay in touch 1 x per month.*
Person's Definition of the outcome (Describes how the person does or would define the outcome)	*I need to talk to my family more often.*
Service(s) Objective(s): **__X__on-going _____wait list**	*1) Jennifer will receive residential habilitation through XYZ agency, Medicaid Waiver and KCRC.* *2) Jennifer will receive personal spending of 30.00 per month monitored by XYZ agency and KCRC.* *3) Jennifer will receive day habilitation (on-site, group) for 5 hours per day, 5 days per week and off-site for 1 hour per day, 5 days per week through WYB agency, Medicaid Waiver and KCRC.*
How do we know the outcome is accomplished?	➢ *Talking to Jennifer and her staff* ➢ *Feedback from family* ➢ *Documentation (staff logs, calendars, etc.) will show evidence that increased contact, more than 1 time per month, is happening consistently for at least one planning year.* ➢ *Jennifer and her team will determine if Jennifer is satisfied with the increased contact.*

What needs to be done? (Action Steps)	**Strategies for Implementation**	**Who's Responsible?**	**Start / Estimated completion**	
1) Jennifer will learn to keep in touch with her family at least weekly (and at her and her family's) request. ("Keeping in touch" is defined by the strategies that work for Jennifer).	a. Purchase a calling card by 5/1/03 by budgeting personal spending funds. b. Make long distance calls to her mother at least 1 x per week, preferably Fridays after 5 pm and help from family. c. Obtain and/or purchase a calendar and address book to record phone numbers and reminders of days to call.	QMRP – Nancy updated monthly and reviewed by SC during visits. QMRP–Nancy XYZ agency AND QMRP – Donna WYB agency (day hab)	4/1/03 5/2/03 4/15/03	5/1/03 Calls are documented weekly – on-going